Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement of $4,435.41 for date of service, 8/16/01.

   b. The request was received on 8/12/02.

II. EXHIBITS

1. Requestor, Exhibit I:

   a. TWCC 60 and Letter Requesting Dispute Resolution
   b. UB-92(s)
   c. EOB/TWCC 62 forms/Medical Audit summary
   d. Medical Records
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

2. Respondent, Exhibit II:

   a. TWCC 60 and Response to a Request for Dispute Resolution
   b. ASC Methodology
   e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.

3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14-day response to the insurance carrier on 9/20/02. Per Rule 133.307 (g) (4), the Carrier representative signed for the copy on 9/20/02. The response from the insurance carrier was received in the Division on 9/26/02. Based on 133.307 (i) the insurance carrier's response is timely.

4. Notice of Additional Information Submitted by Requestor is reflected as Exhibit III of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 9/11/02

"We are appealing the amount disallowed on the above mention [sic] claim. These charges are for **FACILITY FEES**, not professional fees. We feel that 16% paid on a right wrist arthroscopy is not fair or reasonable. We feel that (Carrier) should reimburse us more appropriately as $850.40 does not cover our costs to perform this surgery….Even though there is no real definition in the TWCC rules defining 'reasonable and necessary', we feel our medical services fees are 'fair and reasonable' as outlined in the Texas Labor Code. Our facility's methodology is to bill only the supplies, medications, equipment, procedure room and recovery time that were used during the surgery. The total charges are as ***individual*** as the patients we are treating. It is neither fair nor reasonable to bill a flat or a per diem rate for a procedure/surgery, as the patient may not use certain supplies and medications, or may not spend the same amount of time in the procedure room/operating room or recovery room and still get charged for something that was not consumed…. Recent SOAH decisions indicate that examples of EOBs of what other insurance carriers are willing to pay is not evidence of effective medical cost control and is not evidence of amounts paid on behalf of managed care patients of ASCs or on behalf of other non-workers' compensation patients with equivalent standard of living. The rationale of why we have enclosed the many examples of EOBS serve several different purposes other than the reasons addressed in the SOAH decisions. First, it backs up our claim that other insurance carriers are in fact paying 85% - 100% of our billed charges. Second, contrary to what the ALJ indicates, the examples do show that we do achieve medical cost control, not only by not changing the fees we charge for the use of our facility and equipment as explained above. It also shows that we do in fact bill everyone in the same manner no matter if it is a workers' compensation claim and it is a TWCC subscriber or a workers' compensation claim that is not a TWCC subscriber, if it is an occupational policy, or a group claim. This information not only backs up our statements, it also proves that (Requestor) does indeed follow the Texas Labor Code and the TWCC rules….(Carrier) has unfairly reduced our bill when other worker's compensation carriers' have established that our charges are fair and reasonable."

2. Respondent: Letter dated 9/26/02

"This dispute involves the carrier's payment for date of service 8/16/01. The requester billed $5,285.81; (Carrier) paid $850.40. The requester believes it is entitled to additional money. 1. There is no MAR for outpatient ASC services…. 7. (Carrier's) payment is consistent with the fair and reasonable criteria established in Section 413.011 (b) of the Texas Labor Code…. In this dispute (Carrier) took the CPT code used by the requester and surgeon, 29846, and applied its methodology to determine its fair and reasonable payment of $850.40."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only date of service eligible for review is 8/16/01.

2. This decision is being written based on the documentation that was in the file at the time it was assigned to this Medical Dispute Resolution Officer.

3. Per the Requestor's Table of Disputed Services, the Requestor billed the Carrier $5,285.81 for services rendered on 8/16/01.

4. Per the Requestor's Table of Disputed Services, the Carrier paid the Requestor $850.40 for services rendered on 8/16/01.

5. The Carrier's EOBs denied any additional reimbursement as "M – THE REIMBURSEMENT FOR THE SERVICES RENDERED HAS BEEN DETERMINED TO BE FAIR AND REASONABLE BASED ON BILLING AND PAYMENT RESEARCH AND IS IN ACCORDANCE WITH LABOR CODE 413.011(B)."

6. Per the Requestor's Table of Disputed Services, the amount in dispute is $4,435.41 for services rendered on 8/16/01.

7. The facility provided O.R. services, pharmaceutical products, medical and surgical supplies, non-sterile supplies, IV therapy, anesthesia equipment, and Recovery Room services.

V. RATIONALE

Medical Review Division's rationale:

The medical documentation indicates the services were performed at an ambulatory surgical center. The provider has submitted several examples of other Carrier's EOBs for charges billed for a similar procedure. The carrier has submitted documentation asserting that they have paid a fair and reasonable reimbursement. Respondent has submitted an explanation of their payment methodology.

Per Rule 133.304 (i), "When the insurance carrier pays a health care provider for treatment(s) and/or service(s) for which the Commission has not established a maximum allowable reimbursement, the insurance carrier shall:

1. develop and consistently apply a methodology to determine fair and reasonable reimbursement amounts to ensure that similar procedures provided in similar circumstances receive similar reimbursement;

2. explain and document the method it used to calculate the rate of pay, and apply this method consistently;

3. reference its method in the claim file; and

4. explain and document in the claim file any deviation for an individual medical bill from its usual method in determining the rate of reimbursement."

The response from the carrier shall include, per Rule 133.307 (j) (1) (F), ".... if the dispute involves health care for which the Commission has not established a maximum allowable reimbursement, documentation that discusses, demonstrates, and justifies that the amount the

respondent paid is a fair and reasonable rate of reimbursement in accordance with Texas Labor Code 413.011 and §133.1 and 134.1 of this title;".

The carrier, asserts in their methodology, that they have paid a fair and reasonable reimbursement for all dates in dispute. The carrier indicates in their methodology that two national resources are utilized in determining a fair and reasonable reimbursement, "….1) ASC charges as listed by CPT code in '1994 ASC Medicare Payment Rate Survey' and 2) ASC Group payment rates as determined by the Secretary of the U.S. Department of Health and Human Services for surgical procedures by CPT code….(Carrier) used this data in the following manner; 1) The payment rate for the service in dispute, as defined by the CPT code, is determined using Medicare's ASC Group rates. 2) The median charge from ASCs, weighted by total volume, is determined for the service group. 3) The co-payment amount is determined by multiplying the median weighted facility charge by 20%. 4) The dollar amounts from B.1) and B.3) above are summed to determined the fair and reasonable payment for the service." The carrier then took the CPT code 29846 used by the requester and surgeon and applied the above methodology to arrive at $850.40 payment for date of service in dispute.

Due to the fact that there is no current fee guideline for ASC's, the Medical Review Division has to determine, based on the parties' submission of information, which has provided the more persuasive evidence of what is fair and reasonable. The Respondent has submitted its methodology. However, as the requestor, the health care provider shall provide documentation that "…discusses, demonstrates, and justifies that the payment being sought is fair and reasonable rate of reimbursement…." pursuant to TWCC Rule 133.307 (g) (3) (D). The law or rules are not specific in the amount of evidence that has to be submitted for a determination of fair and reasonable. In this case, the Requestor's example EOBs are reflective of reimbursements received from other Carriers, however, the Requestor fails to define how this information discusses, demonstrates and justifies that the payment being sought represents a fair and reasonable charge for the dates in dispute. Therefore, **no additional** reimbursement is recommended.

REFERENCES: The Texas Workers' Compensation Act & Rules: Sec 413.011 (d); Rule 133.304 (i); Rule 133.307 (g) (3) (D); and (j) (1) (F).

The above Findings and Decision are hereby issued this 28th day of April 2003.

Pat DeVries
Medical Dispute Resolution Officer
Medical Review Division

PD/pd